ARIZONA DEPARTMENT OF ECONOMIC SECURITY

DIVISION OF DEVELOPMENTAL DISABILITIES

THIRD PARTY LIABILITY BILLING GUIDE FOR THERAPY PROVIDERS

Rev. 09/04/08

http://www.azdes.gov/ddd/

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The information in this guide is intended to help the provider with billing insurance companies. Content in this guide is subject to change at any time.

Introduction

This Billing Guide provides a resource to our contracted therapists who are providing services to our consumers. The Division of Developmental Disabilities (DDD) requires Third Party Liability (TPL) billing for all individuals served by contracted service providers. Third Party Liability is defined as any entity that is, or may be, liable to pay all or part of the medical cost of care before the Division of Developmental Disabilities pays towards the claim.

The Division reimburses for covered services only after all available third-party benefits are exhausted. Payments made under the DDD program must be reduced to the extent that they are offset by a third-party resource. As part of their condition of eligibility, per Arizona Administrative code R6-6-1301, during the application process with the Division, the applicant must provide all third party liability information.

Providers are expected to take reasonable measures to ascertain any third-party resource available to the consumer and to file a claim with that third party. In such instances, the Division will not reimburse for the cost of services, which are or would be covered by a third-party payer if billed to that third-party payer and payment is more than the providers contracted rate with the Division. If the provider receives a third-party payment after having received a payment from the Division for the same items and services, the Division must be reimbursed the payment made to the provider.

It is not the intent of the Division to delay payment to a provider for the covered services because of an pending third-party liability. If a payment (or denial) is not forthcoming from the insurance company within sixty to ninety days and the provider has made multiple attempts with the insurance company to try to obtain a payment or denial, the provider should notify the Benefits Coordinator to request help and/or request a waiver. More about the waiver process in Chapter 4**.**

Resources for data gathering in regards to the types of insurance/third-party funding available are pointed out in **Chapter 1.** Providers interested in accessing insurance will want to have an understanding of the variety of health-coverage plans available. The description of private insurance, Health Maintenance Organizations (HMOs), self-funded plans, and other government plans in this chapter will be helpful not only for funding purposes, but also as the provider/service coordinator consults with parents and/or guardians. **Chapter 2** discusses documentation requirements of insurance carriers and HMOs for the initiation and continuation of treatment. Included is a sample Insurance Coverage Verification Form. Information is provided regarding procedure and International Classification of Diseases (ICD-9) codes and the tools providers will need to use to establish fees for services.

A line-by-line approach for completion of the basic Centers for Medicare and Medicaid (CMS) 1500 claim form, which is used for private insurance, HMOs, and AHCCCS, is found in **Chapter 3.**

Chapter 4 provides the reimbursement process of the claim, from gathering the data for services rendered to recording the payment. The waiver process is explained on page 32.

HIPAA

(Health Insurance Portability & Accountability Act of 1996)

HIPAA is a Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. Any healthcare provider that *electronically* stores, processes or transmits medical records, medical claims, remittances, or certifications must comply with HIPAA regulations. "Covered entities" are regulated: HIPAA directly regulates the following three types of "covered entities":

1. Health plans—insurers, HMO's, Medicaid (AHCCCS), etc.;
2. Health care clearinghouses (entities that help health care providers and health plans standardize their health information); and
3. Health care providers who transmit health information in electronic form in connection with a HIPAA transaction. It is important to recognize that there is a two-part determination for deciding whether an entity is a covered health care provider:

   Part one -- A "Health care provider" is defined as any person who, in the normal course of business, furnishes, bills, or is paid for "health care." The term "health care" is defined quite broadly to include preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, service, assessment, or procedure with respect to the physical and mental condition, or functional status of an individual or that affects the structure or function of the human body.

   Part two -- HIPAA transactions are exchanges of information between two parties to carry out financial or administrative activities related to health care, including transactions such as filing a health insurance claim with an insurer and determining eligibility for health insurance.

NPI

(National Provider Identifier)

The Health Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique identifier for health care providers. The NPI is a 10-digit, intelligence-free numeric identifier (10 digit number). Intelligence-free means that the numbers do not carry information about health care providers, such as the state in which they practice or their provider type or specialization. The NPI will replace health care provider identifiers in use today in HIPAA standard transactions. Those numbers include Medicare legacy ID's (UPIN, OSCAR, PIN, etc.). Your NPI will not change and will remain with you regardless of job or location changes. DDD providers billing private insurance companies must include their NPI on all CMS-1500 claim forms. Please see page 29 for instructions of where to list the number.

All health care providers who are HIPAA-covered entities, whether they are **individuals** (such as occupational therapists, physical therapists, or speech language pathologists) or **organizations** (such as hospitals, therapy agencies, clinics, nursing homes, group practices, etc.) must obtain an NPI to identify themselves in HIPAA standard transactions.

Go to http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf to begin the online application process.

Chapter 1

HEALTH INSURANCE CARRIERS AND MANAGED CARE ORGANIZATIONS

There are more than two thousand health insurance carriers in the United States. Besides private / commercial insurance plans, there are also Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's) and Exclusive Provider Organizations (EPO's). Many of these carriers have several types of plans that are tailored to meet the needs of their insured's. The insurance carrier may also be called an insurer, underwriter or administrative agent. The insurance carrier provides coverage as outlined in the contract with the entity purchasing the insurance (employer or individual).

Third-party payers issue an insurance card, which provides the plan information necessary for claims processing. Plan specifics can vary significantly by both carrier and employer specifications. Therefore, even consumers insured by the same carrier may have different plan benefits. The provider's billing personnel should call the insurance carrier, identify themselves as a provider and request information about any policy limitations regarding the services being rendered. A sample benefit inquiry form is on page 23. Most carriers will provide the necessary information. Obtaining coverage limitations prior to initiation of services saves time and administrative costs. The information provided by the carrier is not a guarantee of reimbursement to the provider. More detailed information about this process is explained in Chapter 2.

With the exception of HMO or PPO plans, most standard indemnity carriers do not require prior authorization for evaluation or therapeutic services, but do require standard documentation procedures. It is not unusual for a carrier to request copies of documentation. Payment for services is made to the beneficiary or assigned provider, based on a schedule of benefits for the medical services. Assignment of benefits by the insured does not always guarantee direct payment to the provider. Some policies limit direct payment to the insured, such as some Blue Cross Blue Shield and United Healthcare policies. In these cases, the provider is responsible for tracking funding and seeking payment from the insured.

The following are standard documentation procedures that are accepted by most insurance carriers when services are provided by licensed, certified practitioners:

- Physician authorization / script with the following listed:
    1. Type of therapy
    2. Diagnosis
    3. Duration of treatment
- Documentation of the evaluation and results (report)
- Progress documentation

See Chapter 2 for more complete information about documentation requirements.

The majority of insurance plan changes occur in the month of January. Therefore, it is essential for the provider to verify current plan information given during a consumer's initial intake with the Division, quarterly through the calendar year and again in January if the consumer is continuing to receive Occupational, Physical or Speech Therapy. Filing with a plan that no longer insures the consumer is time-consuming and costly.

Types of Third-Party Payers

Third-party payers can be categorized as follows: Private/Commercial, Blue Cross/Blue Shield (BCBS), Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), self-insured plans, Tricare, Medicare and AHCCCS. The following pages will outline each type of plan.

1. Private Insurance (Commercial)

Up until about 30 years ago, most people had traditional indemnity coverage. These days, it's often known as "fee-for-service" or indemnity. Indemnity plans are somewhat like auto insurance: a certain amount of the medical expense is paid up front in the form of a deductible and afterward the insurance company pays the rest or the majority of the bill.

Fee-for-service plans usually involve more out-of-pocket expenses. Often there is a deductible, usually of about $200-$2,500 before the insurance company starts paying. Once the deductible is paid, the insurer will pay about 80 percent, depending upon the percentage. Most plans offer an 80/20 option although a 70/30 or 60/40 split is not unheard of.

Under fee-for-service plans, insurers will usually only pay for “reasonable and customary" medical expenses, taking into account what other practitioners in the area charge for similar services. Fee-for-service plans often include a ceiling for out-of-pocket expenses, after which the insurance company will pay 100 percent of any costs. The ceiling is usually pretty high.

Medical insurance can be purchased through group or individual policies. Under group insurance, coverage is provided for a number of people through the use of a single policy. The contractual relationship is between the insurer and the named policyholder (usually the employer). Under an individual policy, the insured individual is the policyholder. Group insurance coverage generally costs less and provides more comprehensive coverage than individual coverage because the "risk" absorbed by the insurer is less concentrated, and its administrative costs can be spread over a greater number of persons.

In conclusion, fee-for-service coverage offers flexibility in exchange for higher out-of-pocket expenses, more paperwork and higher premiums.

2. Blue Cross Blue Shield (BCBS)

Blue Cross/Blue Shield (BCBS) functions much as a commercial carrier does, except in its language definitions for contracts and subscribers: BCBS requires providers to meet BCBS standards and enroll in order to become participating providers. The provider requirements for reimbursement by BCBS vary by plan and state.

Historically, there was a clear distinction between the BCBS and "commercial" carriers. The Blue Cross/ Blue Shield concept was based on the promise of provision of hospital/medical services as required by the patient. The insured person was described as a subscriber to Blue Cross/Blue Shield plans; the plans established contractual relationships with hospitals and doctors. In the early 1980's, the BCBS concept began to change. The district Blue Cross and Blue Shield plans combined to form Blue Cross/ Blue Shield of Arizona. Blue Cross/Blue Shield of Arizona now operates as a commercial carrier.

Though it's not in your DDD contract to be an insurance-contracted provider with any commercial insurance company, obtaining an "AZ" number, or Provider Identifier Number from BCBS of Arizona is advisable. Without it, BCBS most likely will not recognize you or the processing of your claim form. When in the BCBS website, click on *Forms and Resources* and click on *Blue Cross Blue Shield of Arizona Non-Contracted Provider Request*. Once you complete the form and fax it to BCBS, they will issue you your number and will advise where to enter the number on the CMS-1500 claim form. If you're interested in becoming a BCBS provider, click on the *Provider Contracting Request and Information Form* and submit it to BCBS for a contractual consideration.

For more information about Blue Cross Blue Shield plans, go to www.bcbsaz.com

3. Managed Care

There are three basic types of managed care plans: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) plans. Although there are important differences between the different types of managed care plans, there are similarities as well. All managed care plans involve an arrangement between the insurer and a selected network of health care providers (doctors, hospitals, etc.). All offer policyholders significant financial incentives to use the providers in that network. There are usually specific standards for selecting providers and formal steps to ensure that quality care is delivered.

The following three pages describe the different plans.

Health Maintenance Organizations (HMOs)

The range of health care services covered by an HMO varies, so it is important to compare available plans. Some health care services, such as outpatient mental health care or therapies, are often only covered on a limited basis. HMOs consist of a network of physicians. From this list, a primary care provider is chosen, who is then responsible for his or her patients health care as well as for making referrals to specialists and approving further medical treatment. Usually, the choice of doctors and hospitals is limited to only those on the list. HMO's tend to be very restrictive and have many rules.

Because the HMO health insurance company charges a fixed fee, it is in their financial interest to make sure the consumer gets basic health care for their medical problems before they become serious. Although there may be a co-payment for each office visit, the total health care costs will likely be lower and more predictable in an HMO than with fee-for-service insurance.

Out of pocket costs for the policyholder are determined by contractual agreements between the employer who buys the plan for their employees and the HMO. Some HMOs don't charge a fee for services such as laboratory testing, mammography testing, and post-op doctor visits.

Advantages and disadvantages of HMO health insurance

The major advantage to HMOs is the cost. HMOs are cheaper for the consumer than other plans. Premiums are lower than those for other types of plans as well. Co-payments are typically ten dollars per doctor visit and ten to twenty dollars for prescriptions. Many people like HMO health insurance because they do not require claim forms for office visits or hospital stays. Instead, HMO members present a card, like a credit card, at the doctor's office or hospital. However, in an HMO you may have to wait longer for an appointment than you would with an indemnity insurance plan.

Since an HMO exercises more control over their policyholders health care than other managed care plans, the cost is also more controlled. On top of the monthly health insurance premium, there are very few other fees when using network providers. For health care services covered under the plan, HMO plans require minimal co-payments for services rendered.

Unfortunately, there are drawbacks to these health insurance plans too. It can be difficult to get specialized care under an HMO plan since the consumer must first obtain a network referral (depending on the HMO and plan). The drawback of any HMO policy is that care received outside of the health care network is not covered. However, exceptions may be made in emergencies.

Preferred Provider Organizations (PPOs)

PPOs lie in between Health Maintenance Organizations (HMOs) and fee-for-service plans (POS plans). A PPO policyholder's health care offers a choice in providers as PPOs are more loosely organized and are not as restrictive as HMOs.

However, a PPO does differ from the original HMO blueprint, primarily in that under a PPO insurance plan, a primary care provider or "gatekeeper" physician is not required. As a result, seeing a specialist does not require a referral. If health care is referred outside of the network, there will be a higher co-payment than if the provider were from within the PPO network so staying within the network is best.

Advantages and disadvantages of PPO insurance

- Health care costs are low when using the PP0 networks.
- Specialists may be consulted, including ones outside the plan.
- Seeing a primary care provider is not a prerequisite.
- Paperwork can be the policyholder's responsibility if the care is non-network.
- Out-of-pocket costs per year are limited.
- Cost of treatment outside of the network is more expensive.
- Co-payments are larger than with other managed care plans.
- There may be a deductible.

PPO insurance is generally the most expensive type of managed care plan. Even with a premium comparable to an HMO, the *other* fees associated with PPO insurance can increase its cost significantly. On top of the premium, the consumer may be expected to pay coinsurance (lower charges if using network providers and higher charges if using non-network providers). For preventative services, co-insurance is usually waived and, instead, but may be replaced with a (low) co-payment.

With non-network care, if there's a deductible, it must be satisfied before the health insurance company begins contributing. After the deductible is met, insured's may pay a higher percentage of the cost and may also be require to pay the difference between what the health care provider charges and what the plan deems to be "reasonable and customary" for the service.

Co-pays are not allowed to be assessed to the families you serve, per your contract with the Division, as the co-pay amount is built into your rate schedule. Please see the Special Terms and Conditions of your contract for more information.

Point of service (POS) plans

The POS is based on the basic managed care foundation: lower medical costs in exchange for more limited choice. But POS health insurance does differ from other managed care plans. When enrolled in a POS plan, the consumer is required to choose a primary care provider to monitor their health care. The primary care provider must be chosen from within the health care network, and becomes the consumers "point of service". POSs are somewhat like an indemnity-type plan.

The primary POS physician may then make referrals *outside* the network, but then only some compensation will be offered by the health insurance company. For medical visits within the health care network, paperwork is completed for the consumer. If the policyholder chooses to go outside the network, it is their responsibility to fill out the forms, send bills in for payment, and keep an accurate account of health care receipts.

Advantages and disadvantages of POS health insurance

- Maximum freedom (for managed care).
- Not limited to only Health Maintenance Organization (HMO) network providers.
- For network care, co-payments are low and there is no deductible.
- Annual out-of-pocket costs are limited.
- Co-payments for non-network care are high.
- There is a deductible for non-network care.
- Getting referrals for specialists may be difficult.

The breakdown of cost under a POS plan is similar to that of other managed care plans. It may be slightly less costly than a Preferred Provider Organization (PPO) because the health insurance company will still regulate most of the health care. Actual costs will consist of the monthly premium and a co-payment for health care services covered under the plan and within the POS network.

There will be a deductible on any non-network care, and after the deductible is met, the consumer will still pay a higher percentage of the cost and possibly the difference between what the health care provider charges and what the plan deems to be "reasonable and customary" for the service.

4. Self-insured Plans

Self-insured plans, Exclusive Provider Organization's (EPO's) represent a form of health insurance under which the healthcare benefits are designed and dictated by the employer. Due to the rapidly increasing high cost of healthcare, this type of health plan is growing because major corporations have found it less costly to provide their own healthcare plans and dictate the benefits.

Some employers and employee groups have been able to achieve cost savings by assuming all or a portion of the risk of health benefits offered to their employees. Some organizations have also demonstrated the ability to realize savings by processing health claims and paying medical care providers directly. These situations of assumed risk and claims administration are usually referred to as "self-insurance" or "self-funded" or "self-administered."

An employer that performs these functions from within its own resources is not "insured" since there is no transfer of risk. The employer retains the potential for loss for all covered medical expenses incurred by the employees and dependents. An employer can transfer some of this risk by purchasing "stop-loss" coverage from a commercial carrier. For a premium, the commercial carrier will assume the covered medical expenses of an individual who has reached some stated threshold, perhaps $50,000 in medical expenses in any one policy year. The employer may also pay for commercial coverage, which reimburses the employer for medical expenses paid out in total, perhaps $1,000,000 for all covered employees.

Self-insured health plans are not subject to the state laws that regulate the insurance industry. The Employee Retirement Income Security Act (ERISA) prohibits individual states from considering self-insured/funded plans as insurance companies for regulation purposes. For regulatory questions regarding self-funded plans contact:

Pension & Welfare Benefits Administration

Room N-6544

200 Constitution Avenue NW

Washington, D.C. 20210

For more information online about the U.S. Department of Labor, go to:

http://www.dol.gov/dol/topic/health-plans/erisa.htm

5. TriCare

TRICARE is a federal program created for the benefit of dependents of personnel serving in the uniformed services. The federal government maintains TRICARE, not as an insurance program, but rather as a service-connected benefit. Tricare coverage is secondary to commercial health plans, but primary over AHCCCS. TRICARE is a health benefit program for all seven uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. To use TRICARE, consumers must be listed in the Defense Enrollment Eligibility Reporting System (DEERS) as being eligible for military health care benefits. The main TRICARE programs are Prime, Standard and TRICARE for Life. Listed below are brief summaries of each as well as the Extended Care Health Option (ECHO) program.

TRICARE Prime offers fewer out-of-pocket costs than any other TRICARE option. TRICARE Prime beneficiaries receive most of their care from a military treatment facility (MTF). A primary care manager (PCM) provides and coordinates the consumer's care, maintains their patient health records, refers them to specialists, and files claims for them. Specialty care must be arranged and approved by the PCM to be covered under TRICARE Prime.

TRICARE Standard and Extra is the basic TRICARE health care program for people not enrolled in TRICARE Prime. (Active duty service members are enrolled in Prime, and many other beneficiaries choose to enroll.) Standard is a fee-for-service plan that gives beneficiaries the option to see any TRICARE-certified/authorized provider (doctor, nurse-practitioner, lab, clinic, etc.). Standard offers the greatest flexibility in choosing a provider, but it will also involve greater out-of-pocket expenses for the consumer. Standard requires that a yearly deductible is satisfied before TRICARE payments begin, and the consumer is required to pay co-payments or cost shares for outpatient care, medications, and inpatient care.

TRICARE for Life (TFL) is an enhanced health care benefit for Medicare-eligible uniformed service retirees. There are no enrollment fees or premiums for TFL, but retirees must be enrolled in Medicare Part B and pay the Part B monthly premium. TFL will pay the out-of-pocket expenses not covered by Medicare and other private health insurance.

Extended Care Health Option In addition to coverage received via the primary TRICARE plan, TRICARE ECHO benefits may include: Medical and rehabilitative services, training to use assistive technology devices, special education, institutional care when a residential environment is required, transportation under certain circumstances, assistive services, such as those from a qualified interpreter or translator, for beneficiaries whose visual or hearing impairment qualifies them for ECHO benefits, durable equipment, including adaptation and maintenance, in-home medical services through TRICARE ECHO Extended Home Health Care (EHHC), in-home respite care services if homebound. For information about ECHO, call 1-866-876-2384 (ext. 67607 or 48410).

For more information about Tricare, go to: www.tricare.mil

6. Medicare

Medicare is a health insurance program for people age 65 and older, people under 65 with certain disabilities and people of all ages with end-stage renal disease. Medicare is comprised of “Parts” – Part A, hospital insurance, Part B, medical (outpatient) insurance and Part D, the prescription drug benefit.

Medicare will pay for most health care expenses, but not all of them. In particular, Medicare does not cover most nursing home care or long-term care services in the home. Medicare usually operates on a fee-for-service basis. Health Maintenance Organizations (HMOs) and similar forms of prepaid health care plans such as Preferred Provider Organizations (PPOs) are also available to Medicare enrollees. There are four main Medicare Advantage Plans: Medicare HMO Plans, PPO Plans, Special Needs Plans and Private Fee-For-Service Plans.

The best source of information on the Medicare program is the *Medicare Handbook*. This booklet explains how the Medicare program works and what the benefits are. The handbook can be ordered, free of charge, by writing to: Health Care Financing Administration, Publications, N1-26-27, 7500 Security Blvd., Baltimore, MD 21244-1850. The handbook can also be viewed online. See the web address below.

Some people who are covered by Medicare buy additional private insurance, called "Medigap" policies, to pay the medical bills that Medicare doesn't cover. Those policies are secondary to Medicare. Some Medigap policies cover Medicare's deductibles and most pay the coinsurance amount. Some also pay for health services not covered by Medicare. Some DDD consumers may qualify for a Qualified Medicare Beneficiary (QMB) plan as a secondary. See the chart on page 16 for more about that and other plans.

For more information about Medicare, go to: www.medicare.gov

7. Arizona Health Care Cost Containment System (AHCCCS)

The AHCCCS acute care program has matured into a national model for the delivery of managed care. Likewise, the Arizona Long Term Care System (ALTCS) has been recognized as a model for delivering long term care services in a managed care environment. In 1981, because of their concern about the growing cost of indigent health care and the burden to the counties, the Governor and the Arizona Legislature began to explore various options which would relieve the counties' fiscal problems by bringing Medicaid dollars into the State for the first time. On October 1, 1982, Arizona became the last state in the nation to implement a Medicaid program. Prior to that time, health care for the indigent was provided and fully funded by the Arizona counties. AHCCCS health care coverage is comprised of:

- Acute care services including outpatient health services, hospital, pharmacy and durable medical equipment, laboratory and x-ray, specialty care, home health and family planning.
- Long term care services including home and community based services (HCBS), alternative residential settings, nursing facilities, intermediate care facilities for the mentally retarded, hospice, acute care services, case management, and behavioral health.
- Payment of Medicare premiums, coinsurance and deductibles for individuals who are Qualified Medicare Beneficiary (QMB) Only (no services are provided by AHCCCS), and
- Emergency services only for individuals who qualify for the Federal Emergency Services (FESP) and State Emergency Services (SESP) programs.

Depending upon which county a consumer lives in, they can choose from different health plans, under the AHCCCS umbrella. Listed below are contact names, phone numbers and web addresses:

Mercy Care Plan	800-624-3879	http://www.mercycareplan.com
Care 1st Arizona	866-560-4042	http://www.care1st.com
Phoenix Health Plan	800-747-7997	http://www.phoenixhealthplan.com
Maricopa Health Plan	800-582-8686	http://www.mhpaz.com
Pima Health Plan	800-423-3801	http://www.pimahealthsystem.org
APIPA	800-348-4058	http://www.myapipa.com
Health Choice AZ	800-322-8670	http://www.healthchoiceaz.com
University Family Care	800-582-8686	http://www.ufcaz.com

For more information about AHCCCS, go to: www.azahcccs.gov

AHCCCS ELIGIBILITY REQUIREMENTS April 1, 2008

Where to Apply	Eligibility Criteria: Household Monthly Income by Household Size (After Deductions)[1]	Resource Limits (Equity)	Social Security #	Special Requirements	General Information: Benefits
Coverage for Children					
S.O.B.R.A. Children Under Age 1 DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	Child living alone $1,214 Child living with 1 parent ½ of $1,634 Child living with 2 parents 1/3 of $2,054	N/A	Required	N/A	AHCCCS Medical Services[3]
S.O.B.R.A. Children Ages 1 – 5 DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	Child living alone $1,153 Child living with 1 parent ½ of $1,552 Child living with 2 parents 1/3 of $1,951[2]	N/A	Required	N/A	AHCCCS Medical Services[3]
S.O.B.R.A. Children Ages 6 – 19 DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	Child living alone $ 867[2] Child living with 1 parent or spouse ½ of $1,167 Child living with 2 parents 1/3 of $1,467	N/A	Required	N/A	AHCCCS Medical Services[3]
KidsCare Children Under Age 19 Mail to KidsCare 920 E. Madison, MD 500 Phoenix, Arizona 85034	1 $1,734 2 $2,334 3 $2,934 4 $3,534 Add $600 per Add'l person	N/A	Required	• Not eligible for Medicaid • No health insurance coverage within last 3 months • Not available to State employees, their children, or spouses • $10-35 monthly premium covers all eligible children only • Premium included in parents if parent is covered under Health Insurance for Parents	AHCCCS Medical Services[3]
Coverage for Families or Individuals					
AHCCCS for Families with Children DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	1 $ 867 2 $1,167 3 $1,467 4 $1,767 Add $300 per Add'l person	N/A	Required	• Family includes a child deprived of parental support due to absence, death, disability, unemployment or underemployment	AHCCCS Medical Services[3]
AHCCCS Care (AC) DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	Applicant living alone $ 867 Applicant living with spouse ½ of $1,167	N/A	Required	• Ineligible for any other categorical Medicaid coverage	AHCCCS Medical Services[3]
Health Insurance for Parents DES/Family Assistance Office Call 1-800-352-8401 for the nearest office or Mail to KidsCare 920 E. Madison, MD 500 Phoenix, Arizona 85034	1 $1,734 2 $2,334 3 $2,934 4 $3,534 Add $600 per Add'l person	N/A	Required	• Ineligible for any categorical Medicaid coverage • Parent living with a child who is eligible under S.O.B.R.A. or KidsCare • No health insurance coverage within last 3 months • Not for State employees, their children, or spouses • Monthly premium of 3% to 5% of income for all covered parents and KidsCare Children • $15-$25 per parent enrollment fee before coverage can begin	AHCCCS Medical Services[3]
Medical Expense Deduction (MED) DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	1 $ 347 2 $ 467 3 $ 587 4 $ 707 Add $120 per Add'l person	$100,000 No more than $5,000 liquid	Required	• Ineligible for any other Medicaid coverage. • May deduct allowable medical expenses from income	AHCCCS Medical Services[3]
Coverage for Women					
S.O.B.R.A. Pregnant DES/Family Assistance Office Call 1-800-352-8401 for the nearest office	For a pregnant woman expecting one baby: Applicant living alone $1,750 Applicant living with: 1 parent or spouse2/3 of $2,200 Applicant living with 2 parents 1/2 of $2,650 (Limit increases for each expected child)	N/A	Required	Need proof of pregnancy	AHCCCS Medical Services[3]
Breast & Cervical Cancer Treatment Program Well Women Healthcheck Program Call 1-888-257-8502 for the nearest office	N/A	N/A	Required	• Under age 65 • Screened and diagnosed with breast cancer, cervical cancer, or a pre-cancerous cervical lesion by the Well Woman Healthcheck Program • Ineligible for any other Medicaid coverage	AHCCCS Medical Services[3]

Revised Eff. 04/01/2008

AHCCCS ELIGIBILITY REQUIREMENTS April 1, 2008

Application: Where to Apply	Eligibility Criteria: Household Monthly Income by Household Size (After Deductions)[1]	Resource Limits (Equity)	Social Security Number	Special Requirements	General Information: Benefits
Coverage for Elderly or Disabled People					
Long Term Care ALTCS Office Call 602-417-7000 or 1-800-654-8713 for the nearest office	$ 1,869 Individual	$2,000 Individual[4]	Required	• Requires nursing home level of care or equivalent • May be required to pay a share of cost • Estate recovery program for the cost of services received after age 55	AHCCCS Medical Services[3], Nursing Facility, Home & Community Based Services, and Hospice
SSI CASH Social Security Administration	$ 623 Individual $ 934 Couple	$2,000 Individual $3,000 Couple	Required	• Age 65 or older, blind, or disabled	AHCCCS Medical Services[3]
SSI MAO Mail to SSI MAO 701 E Jefferson MD 400 Phoenix, Arizona 85034	$ 867 Individual $1,167 Couple	N/A	Required	• Age 65 or older, blind, or disabled	AHCCCS Medical Services[3]
Freedom to Work Mail to: 701 E Jefferson MD 7004 Phoenix, AZ 85034 602-417-6877 1-800-654-8713 Option 6	$2,167 Individual Only Earned Income is Counted	N/A	Required	• Must be working and either disabled or blind • Must be age 16 through 64 • Premium may be $0 to $35 monthly + Need for Nursing home level of care or equivalent is required for Long Term Care (Nursing Facility, Home & Community Based Services, or Hospice)	AHCCCS Medical Services[3] Nursing Facility, Home & Community Based Services, and Hospice
SSDI-Temporary Medical Coverage Mail to: SSDI-TMC 700 E Jefferson Phoenix, AZ 85034 602-417-6602 1-877-654-8713 ext 76692	No income limit Important Notice About the SSDI-Temporary Medical Coverage Program http://www.azahcccs.gov/Services/ProgramChangesFY09Budget/Default.asp	N/A	Required	• Receiving Social Security Disability Income • Not eligible for Medicare • No Other health insurance coverage • Premium may be $60 to $300 monthly	AHCCCS Medical Service[3]
Coverage for Medicare Beneficiaries					
QMB Mail to SSI MAO 701 E Jefferson MD 400 Phoenix, Arizona 85034 Or call 602-417-7000 or 1-800-654-8713 for the nearest ALTCS office	$ 867 Individual $1,167 Couple	N/A	Required	• Entitled to Medicare Part A	Payment of Part A & B premiums, coinsurance, and deductibles
SLMB Mail to SSI MAO 701 E Jefferson MD 400 Phoenix, Arizona 85034 Or call 602-417-7000 or 1-800-654-8713 for the nearest ALTCS office	$ 867.01 – $ 1,040 Individual $1,167.01 – $1,400 Couple	N/A	Required	• Entitled to Medicare Part A • Not receiving Medicaid benefits	Payment of Part B premium
QI-1 Mail to SSI MAO 701 E Jefferson MD 400 Phoenix, Arizona 85034 Or call 602-417-7000 or 1-800-654-8713 for the nearest ALTCS office	$ 1,040.01 – $1,170 Individual $1,400.01 – $1,575 Couple	N/A	Required	• Entitled to Medicare Part A • Not receiving Medicaid benefits	Payment of Part B premium

Applicants for the above programs must be Arizona residents and either U.S. citizens or qualified immigrants and must provide documentation of identity and U.S. Citizenship or Immigrant status. Applicants for S.O.B.R.A., AF Related, AC, MED, SSI-MAO, and Long Term Care who do not meet the citizen/immigrant status requirements may qualify for Emergency Services.

NOTES: 1 Income deductions vary by program, but may include work expenses, child care, and educational expenses.
2 Income considered is the applicant's income, plus a share of the parent's income for a child, or a share of the spouse's income for a married person.
3 AHCCCS Medical Services include, but are not limited to, doctor's office visits, immunizations, hospital care, lab, x-rays, and prescriptions.
4 If the applicant has a spouse living in the community, between $20,880 and $104,400 of the couple's resources may be disregarded.

Revised Eff. 04/01/2008

ROLE OF THE DEPARTMENT

The law does not provide the Department with the authority or resources to adjudicate individual claims or contracts between insurers and providers. Rather, the Legislature mandated the grievance system for provider disputes.

1. Providers should send grievance(s) directly to the insurer. They may copy the Department's Timely Pay & Grievance Analyst for information purposes.
2. If a provider contacts the Department about an unpaid claim or other grievance, the Department will refer the provider to the insurer's designated Grievance Contact Person.
3. The Department monitors the copies of grievances it receives from providers as well as the insurers' semi-annual grievance reports.
4. Providers that are unable to get a copy of an insurer's written grievance policy from an insurer, or who need the name of an insurer's grievance contact person, may contact the Department for assistance.

The Department only has authority to enforce the Timely Pay & Grievance law as it applies to payors under the Department's jurisdiction. The following payors are NOT under the Department's jurisdiction:

AHCCCS (Medicaid)
Medicare
Worker's Compensation
Federal Employee Benefit Programs
County/Municipal Health Systems
Self-Insured Employer Plans
Insurers Not Authorized in Arizona

FOR MORE INFORMATION:

www.id.state.az.us

Timely Pay & Grievance History:

HB2600 (effective January 1, 2001)

HB2138 (effective January 1, 2006)

Timely Pay & Grievance Statutes:

A.R.S. § 20-3101

A.R.S. § 20-3102

Regulatory Bulletin:

Regulatory Bulletin 2006-02

QUESTIONS?

Arizona Department of Insurance

2910 N. 44th St., #210
Phoenix, AZ 85018

400 W. Congress St., #152
Tucson, AZ 85701

Phone: (602) 364-2394
Fax: (602) 364-2175

Email: providerinfo@id.state.az.us

May 2006

Persons with disabilities may request that materials be presented in an alternative format by contacting the ADA Coordinator at (602) 364-3100. Requests should be made as early as possible to allow time to procure the materials in an alternative format.

Timely Pay & Grievance Law

Information for Health Care Providers

Janet Napolitano, Governor
Christina Urias, Director

Arizona Department of Insurance

Life & Health Division

In 2000, the Arizona Legislature passed House Bill 2600, creating the Timely Pay & Grievance law, governing the timely payment of health care provider claims. The law requires health care insurers to establish a system for processing disputes between providers and insurers.

In 2005, the Legislature passed HB 2138, which has added definitions to the law and clarified requirements for claims processing, grievance systems, and payment adjustments.

This pamphlet from the Arizona Department of Insurance summarizes the Timely Pay & Grievance law and explains what assistance is available from the Department for health care providers.

CLAIMS PROCESSING

1. A clean claim is one that an insurer can process without obtaining additional information, including coordination of benefits information.
2. If a claim is not clean, and an insurer requires additional information, the insurer must send a written request for the information within 30 days of receipt of the claim or within a time frame designated by contract. The insurer must specify the reason(s) it cannot adjudicate the claim.
3. An insurer must record the date it receives any additional information that the insurer requested.
4. An insurer may not require a provider to submit information a provider can document it has already provided, unless the insurer can provide reasonable justification and the purpose is not to delay the claim.
5. The Department expects insurers to have a written policy available to providers that describes how providers may document they have already submitted the information the insurer wants them to resubmit.

ADJUDICATION AND PAYMENT

1. Under the law, adjudication and payment of clean claims are two separate steps. "Adjudication" means to make a decision on whether to pay or deny, in whole or in part, including the decision on the amount to pay.
2. Insurers must adjudicate clean claims within 30 days of receipt, or within a time frame designated by contract.
3. Insurers must pay any approved portions of clean claims within 30 days of adjudication, or within a time frame designated by contract.
4. Insurers that do not pay clean claims on time must pay interest at 10% per annum or another amount designated by contract. Interest begins accruing on the date payment is due.

ADJUSTMENTS

1. Neither an insurer nor a provider may request an adjustment of a claim more than one year after an insurer has paid or denied the claim.
2. An insurer and provider may designate a different time limit for adjustment by contract provided that limit applies equally to the insurer and to the provider.

GRIEVANCES

A provider grievance is any written complaint subject to the Timely Pay & Grievance law, except:

- A complaint by a non-contracted provider about not being in an insurer's network.
- A complaint by a provider about an insurer's decision to terminate the provider from the insurer's network.
- An issue subject to health care appeals laws governing benefit coverage and/or medical necessity (A.R.S. § 20-2530 et seq.) *See the Department's website for a separate brochure on the health care appeals laws.*

INSURER GRIEVANCE SYSTEMS

Each insurer:

- Must have a written grievance policy that is available to providers upon request.
- Must designate a contact person to receive grievances and answer provider questions on those grievances.
- May recommend, but may not require, a specific form for the submission of grievances.
- Must submit semi-annual grievance reports to the Department, which include information such as the number of grievances received by an insurer, the kinds of grievances, and the time to resolution.

NOTES

The Timely Pay and Grievance law:

- Applies to both contracted and non-contracted providers.
- Has no impact on contractual or policy provisions which are not addressed by the statute (such as time periods for initial claim submission).

Chapter 2

DOCUMENTATION

Most private insurance carriers and Health Maintenance Organizations (HMOs) outline the minimal documentation they require for payment of claims. For example, some insurers require provider/ physician orders (scripts) for the evaluation and continuation of treatment but do not require standardized and formal daily notes or progress note documentation. Upon request, you must be able to produce standardized documentation regarding the services provided. By using the Insurance Coverage Verification form and calling the insurance company before services are rendered, you'll know up front what is needed for the CMS-1500 form. Please see page 23 for an example of the Insurance Coverage Verification form.

Documentation serves the following purposes:

- It provides a record of the consumer's condition and the course of treatment from initiation of the Individual Service Plan (ISP) through the time of discharge.
- It serves as an information source for families.
- It facilitates communication among the professionals involved with the consumer.
- It provides a method for documenting quality assurance.

ELIGIBILITY AND VERIFICATION OF BENEFITS

1. Call the Benefits Verification department of the insurance carrier. The phone number can generally be found on the back of the insurance identification card. If you do not have a copy of the card, use the general phone number for the insurance company provided by the family on the referral form.

2. Identify yourself as a provider and that you want to verify benefit coverage. The insurance company representative will ask you for your provider identification number or your social security number, and upon verifying your information, will ask for the name, policy number, and date of birth for the consumer. The representative will ask you what type of benefits you are calling to verify (Nursing, Occupational Therapy, Physical Therapy, or Speech Therapy).

3. The representative will likely tell you that the verification of benefit is a "quote only" and not a guarantee of payment. A final determination regarding reimbursement will be made when the actual claim is mailed in or sent electronically and reviewed by the insurance company. The representative will most likely tell you whether or not the service is covered and what the rate of reimbursement is. For example, "This policy does have speech therapy benefits, payable at 80% of usual and customary charges, subject to a calendar year deductible of $250". That simply means that they will reimburse you for 80% of your fee, if your fee is considered reasonable for the service provided, and if the deductible for your consumer has already been met for the current calendar year. (See page 47 for more information about payment for deductibles.)

4. If the insurance representative does not volunteer any information about policy limitations, ask if there are any. Here are a few examples of limitations that an insurance company might have for speech therapy benefits:

    - Services must be provided by a licensed S&LP (Speech & Language Pathologist)
    - A referral must be made by the primary care provider
    - A pre-certification, or pre-authorization is required
    - Services must be medically necessary
    - Limited number of visits per year
    - Limited number of visits per diagnosis
    - Maximum amount payable per year
    - Maximum amount payable per lifetime
    - Reimbursement is made only for a particular diagnosis or event
    - Reimbursement is made only to preferred providers / in-network providers
    - A lower rate of reimbursement may be available for non-preferred providers of their company
    - Benefits payable by insurance carriers generally have some type of limitations.

5. *Verify the claims billing address*. Many insurance carriers have separate claims-paying facilities, and if the claim is sent to the wrong address, it will add several weeks to the processing time if the claim is even forwarded.

6. Ask about online billing, if the insurance company website offers it. Not only does this type of billing expedite and ease the billing process, but you can also find out within 24 hours if the claim has been accepted. In most cases, you can receive the Explanation of Benefits (EOB) within a week or so. Some insurance companies will allow you to print out the EOB from the website.

7. Be sure to get the name of the person you spoke with, and write down the information you receive. You can write down the information you receive on the Insurance Coverage Verification Form (see page 23 for example). If you do not fully understand the insurance company quote, ask again or call again.

8. If the services are not covered by the family's private insurance carrier, ask the representative to state that in writing, and send/fax you the statement or letter for your records. You will then have evidence that the carrier should not be billed for the services, and you will be permitted to bill the Division directly, without having to bill the insurance carrier first. You must submit a copy of the statement or letter from the insurance company to the Division with your initial claim for each type of service. Rarely does this occur but it's worth asking about.

9. Initiate services, and once performed, bill the appropriate insurance company on the CMS-1500. See example of form on page 30.

In Summary:

Never rely on what you think is true about benefits or providers covered under the plan - even if they are stated in the family's most recent benefits handbook. Always double-check whether the benefits or services are covered under the consumer's plan before therapy services are rendered. Per your contract with the Division, you must bill the insurance company, however, you'll be one step ahead by knowing the benefit. Remember to take notes. Get the representative's name and write it down, along with the date, time, and general details of your conversation. If a claim problem arises and you need to file a grievance, these notes will come in handy. Most insurers customer-service phone calls are tape recorded. Having the date and time of your call will make locating your call history with the representative much easier. Plus, the representative will be less apt to disregard your request if you have clear and concise information about your past call.

Participation / Consent Form

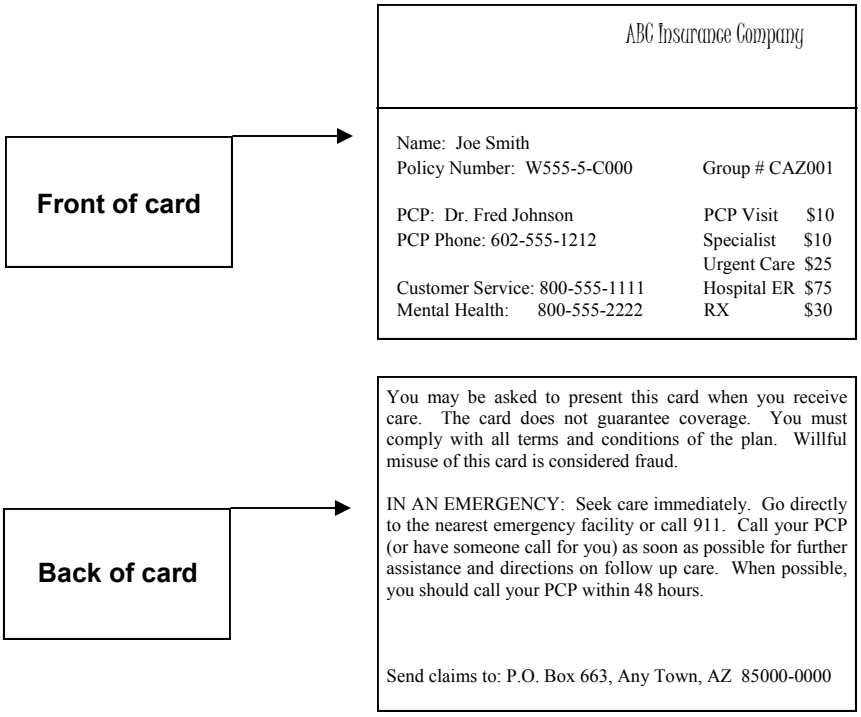
The Third Party Liability form (or the provider's own similar form) must be signed by the policyholder or individual consenting to having the Third Party Liability billed. The policyholder can also sign the CMS-1500 in boxes #12 and #13. By signing, the authorizer is allowing the release of medical information to insurance that is necessary for processing a claim and assigns benefits to the provider.

If the consumer or consumer's family state their private health insurance has been canceled and there is no other private insurance, they should be advised to contact the Support Coordinator or Benefits Coordinator to update the Third Party Liability (TPL) record. Once the TPL record has been updated, the provider may bill the Division directly.

Physician Script

In order for a provider to bill private insurance plans, it is mandatory to have a primary care provider's (PCP) script. The script should detail if the therapy is for an initial evaluation and/or treatment, what type of therapy, frequency, duration of treatment and any special instructions. Before the therapy referral is sent/given to the therapist, the support coordinator will already have sent the Request for Therapy Prescription letter to the primary care provider and it should be included with the therapy referral to you. The physician or providers orders should be maintained in the treatment record. The script is only good for one year from the date it was signed.

Insurance Card example



Each insurance card is different, depending on the format the insurance company uses. Some items on the card are called different names, such as group number and account number.

The main items to look for on the card are the following:

1. Policy number
2. Group number (sometimes called the Account Number)
3. Insured
4. Claims address
5. Customer Service telephone number

Third Party Liability

(For Provider's records)

Consumer Information

Consumer Name: _____ DOB: _____ Sex: M F

Home address: _____ Home Phone #: _____

City, State, ZIP: _____ Work Phone #: _____

Insured Name (person who has insurance policy): _____

Insured's Employer: _____ Insured's DOB: _____

Insurance Information

Insurance Name: _____

Policy Number: _____ Group Number: _____

Effective Date: _____ Termination Date: _____

Claims Address: _____

Insurance Co. Customer Service Phone #: _____

Insurance Co. Prior Authorization Phone #: _____

Physician's Name & Phone #: _____

Authorization to bill insurance

I authorize the release of any information necessary to file a claim to my insurance company. I authorize payment of benefits to name of provider. If sent to me, I will give copies of Explanation of Benefits and payments received from my insurance company to named provider of services provided.

_____ _____

Insured's Signature **Date**

Patient Name: _____

Date of birth: _____

INSURANCE COVERAGE VERIFICATION FORM

Insurance Company: _____ Rep Name: _____

Phone #: _____ Date: _____ Time: _____

Prior Authorization #: _____ Policyholder Name: _____

Claims Address or Payer ID #: _____ Policy No.: _____

_____ Group No.: _____

_____ Employer:_____

Effective date of coverage: _____ Term Date (if applicable):_____

What type of Plan?: HMO EPO PPO Other

Network choice?: In In & Out

Coverage for: OT? ___PT? ___ST? ___

Limit to number of visits? Yes / No

Prior Authorization Required? Yes No Auth# _____

Phone#: _____ Dates Authed: _____ # of visits: _____

FAX#: _____ Contact Name:_____

Letter of Medical Necessity Required: Yes / No

Accept Electronic Claims?: Yes / No

Physicians Name: _____

Diagnosis & ICD-9 Codes:

Phone #: _____

1. _____

FAX #: _____

2. _____

Paperwork required with claims submission:

3. _____

_____

4. _____

_____

CPT CODING

CPT is a list of descriptive terms and identifying codes for reporting medical services and procedures by physicians and other healthcare providers. The purpose of CPT is to provide a standard language that describes medical, surgical, and diagnostic services, and serves as a method for nationwide communication among physicians, patients, and third party payers including Medicare, Worker's Compensation, Personal Health, and Automobile lines of insurance. The provider should select the procedure code that most accurately identifies the services performed. It is unnecessary to provide the written description on the filing form when the numeric code is provided. For procedure codes, refer to the *Physicians' Current Procedural Terminology, (CPT).* Books listing the codes may be purchased from a local technical bookstore or from Order Department: American Medical Association, 515 N. State Street, Chicago, Illinois 60610. Toll free ordering: 800-621-8335.

You can also access CPT code information on the following website: https://catalog.ama-assn.org/Catalog/home.jsp. Click on CPT Online. Under "Downloadable Coding Products/Education (CPT Online)", click on "CPT Code/Value Search".

DIAGNOSTIC International Classification of Diseases 9th Revision (ICD-9) CODING

Insurance companies require the use of ICD-9-CM codes in the billing format on all claim forms. There is space for listing up to four codes in section 21 on the standard billing claim form, the Centers for Medicare & Medicaid Services (CMS) 1500. The primary diagnosis, the condition considered to be the major health problem for which the particular treatment is provided, should be listed first. All diagnoses affecting the current treatment of the consumer should be included. If using internet sites, or other resources to obtain codes, it is the provider's responsibility to ensure that the submitted codes are valid and consistent with the ICD-9 coding manual before submitting claims to an insurance company. Using the correct and age-appropriate diagnosis impacts benefit payments. Always use the fourth and fifth digits when indicated as necessary to further explain the diagnosis.

You can buy the American Medical Association's ICD-9 book through the Order Department, American Medical Association, PO Box 930876, Atlanta, GA 31193-0876. Orders can be called in to: 800-621-8335 or faxed in to: 312-464-5600.

There are several free websites to access ICD-9 Codes:

- http://icd9cm.chrisendres.com/index.php
- http://www.cdc.gov/ncbddd/dd/default.htm
- http://www.eicd.com/

Please keep in mind that obtaining the most current/correct code is the provider's responsibility.

CHAPTER 3

INSURANCE FILING FORM PREPARATION

After written permission has been obtained from the consumer's family, insurance benefits have been verified and services are rendered, the provider or their billing company will bill the appropriate third party. The Division will reimburse providers as the payer of last resort - private insurance plans are *always* billed first. Providers may bill the Division first only for families with no private insurance or in instances where insurance cannot be billed. In that instance, the provider would need to contact the Benefits Coordinator.

If the child is covered by both a private insurance plan and AHCCCS, bill the private insurance plan first, then bill the Division.

Establishing Rate Schedules

The provider determines a fee for each type of service (procedure) to be filed to the third party. Insurance carriers and Health Maintenance Organizations (HMOs) routinely reimburse providers on a standardized U&C (usual and customary) fee-per-procedure code, which is calculated based on the standard fees submitted by providers within the same grouping and geographical area. Some carriers fund for the fee submitted by the provider if the fee is lower than the customary fee. Providers may wish to call other local healthcare providers to obtain data regarding community standards when developing fee schedules.

Providers of healthcare routinely calculate U&C (usual and customary) charges based on the costs of providing services. Providers need to consider the following parameters when determining fees for related services:

- Equipment costs and depreciation
- Consumable supply costs
- Indirect department costs - costs associated indirectly with services, (such as typing, office supplies, billing forms, scheduling, etc.)
- Personnel costs - direct treatment time and preparation time for practitioners Administrative costs
- Profit margin

One rule of thumb providers use is to charge 2.5 times as much the current Medicare rate.

For more information about establishing your rates, check with your therapy professional association or check online for rate spreadsheet examples.

The Centers for Medicare & Medicaid Services Claim Form (CMS 1500)

Treatment date and charge information flows from the provider to the third-party payer via the claim form. The standard claim form, adopted by the American Medical Association is the Uniform Health Insurance Claim Form, known as the CMS 1500, formerly the HFCA 1500. It is accepted by all private insurance carriers, self-funded plans, and HMOs/PPOs/EPOs in the United States These forms are available from a medical supplier, medical bookstore, some office supply stores, or the American Medical Association. Information regarding cost can be obtained by contacting the AMA at (800) 621-8335. If you hand-write the claim form, use CAPITAL letters and write in black ink.

If you are not billing electronically, consider it!

CMS 1500 REQUIREMENTS

The CMS 1500 Claim Form is separated into two parts. The first part (blocks 1-13) contains information about the patient and the insured. The second part (blocks 14-33) contains information regarding the services provided by the provider. Please note that not all sections need to be completed.

The following procedures should be used when completing the CMS 1500 form. (See copy of CMS 1500 form on page 30.)

1. **Payor type:** Optional.

1a. **Insured's Identification number:** Enter the insured's policy identification number, including any letters. This number is found on the insured's insurance identification card.

2. **Patient's name:** Enter the full name of the consumer, including complete last name, first name and middle initial.

3. **Date of birth and sex:** Enter the consumer's date of birth in a month, day and year format. Enter an “X” in the appropriate box either for Male or Female.

4. **Insured's name:** Enter the complete name of the insured.

5. **Patient's address:** Enter the consumer's complete address.

6. **Patient relationship to insured:** Enter an "X" in the appropriate box.

7. **Insured's address:** Enter the insured's complete address.

8. **Patient status:** Optional.

9. **Other insured's name:** If the consumer is covered by additional insurance plans, enter the name. **This only happens when there are two private insurance plans for the consumer.**

9a. **Other insured's policy or group number:** If the consumer is covered by additional insurance plans, enter any available policy numbers of those plans in this section.

9b. **Other insured's date of birth:** Enter other insured's date of birth in a month, date and year format.

9c. **Employer's name:** Enter the complete name of the other insured's employer.

9d. **Insurance plan name:** Enter the other insured's plan or group name

10. **Is patient's condition related to:** Not required.

11. **Insured's policy group or FECA number:** Enter the "group number or "group name" found on the insurance identification card.

11a. **Insured's date of birth and sex:** Enter the insured's date of birth in a month, day and year format. Enter an “X” in the appropriate box either for Male or Female.

11b. **Employer's name:** Enter the complete name of the insured's employer.

11c. **Insurance plan or program name:** Enter the program or group plan name.

11d. **Is there another health benefit plan:** Enter an "X" in the appropriate box. If yes, complete 9 a-d.

12. **Authorized person's signature:** It is imperative that the parent or guardian sign a release of information prior to billing the insurance carrier. The release allows the provider to share information with the insurance carrier that is necessary to process claims. "Signature on file" can then by typed into this space.

13. **Authorized person's signature:** The signature of the insured is required to allow the carrier to pay benefits directly to the provider and thus it is wise for the provider to maintain a written "assignment of benefits" on file from every family with private insurance. Carriers will generally accept "Signature on file" in this space and pay directly to the provider.

14. **Date of illness or injury:** Not required.

15. **If patient has had same or similar illness give first date:** Not required.

16. **Dates patient unable to work in current occupation:** Not required.

17. **Name of referring physician:** Not required.

17a. **ID number of referring physician:** Not required.

18. **Hospitalization dates related to current services:** Not required.

19. **OMIT**

20. **OMIT**

21. **Diagnosis or nature of illness:** Enter the ICD-9-CM number(s) related to the services provided. Up to four codes may be listed, with the primary code first—always list the most critical diagnosis first. One individual code per service may be entered.

22. **OMIT**

23. **OMIT**

24. **Date(s) and Place(s) of Service:**

Column A — Date of service: Enter month, day, and year that relate to the service or procedure provided. The "From" and "To" should always be the same.

Column B — Place of service: Enter the place of service code, using the codes listed on the back of the claim form. Common codes used are 11 (Office), 12 (Home) and 99 (Community).

Column C — EMG: Leave blank.

Column D — Procedures, services: Enter the appropriate procedure code (CPT4).

Column E — Diagnosis Pointer: Corresponds to #21. List as 1, 2, 3 and so forth.

Column F — Charges: Enter the charges for the procedures provided.

Column G — Units: Enter the number of units in relation to the dates of service and procedure code.

Column H. — Leave blank.

Column I. — Leave blank.

Column J. — Enter the individual provider's NPI if the individual provider is part of an agency.

25. **Federal tax ID number:** Enter the EIN or social security number of the provider.

26. **Patient's account number:** Enter the consumer's account number if one has been established for your business, for tracking purposes. This box is not necessary.

27. **Accept assignment:** The provider indicates by making an "X" in the appropriate box whether or not it will accept assignment. It's best to always mark an "X" in the yes box.

28. **Total charges:** Enter total of all the charges itemized in Section 24, Column F.

29. **Amount Paid:** Leave blank, unless this claim is to the secondary insurance carrier and reimbursement has been received from the primary carrier. Then enter the amount received.

30. **Balance due:** Enter the Total charges amount from Box 28, or if primary carrier reimbursement is known, enter balance due.

31. **Signature of provider:** The provider or authorized representative must sign the provider's name, credentials and date. Most carriers accept a signature stamp or computer-generated signature.

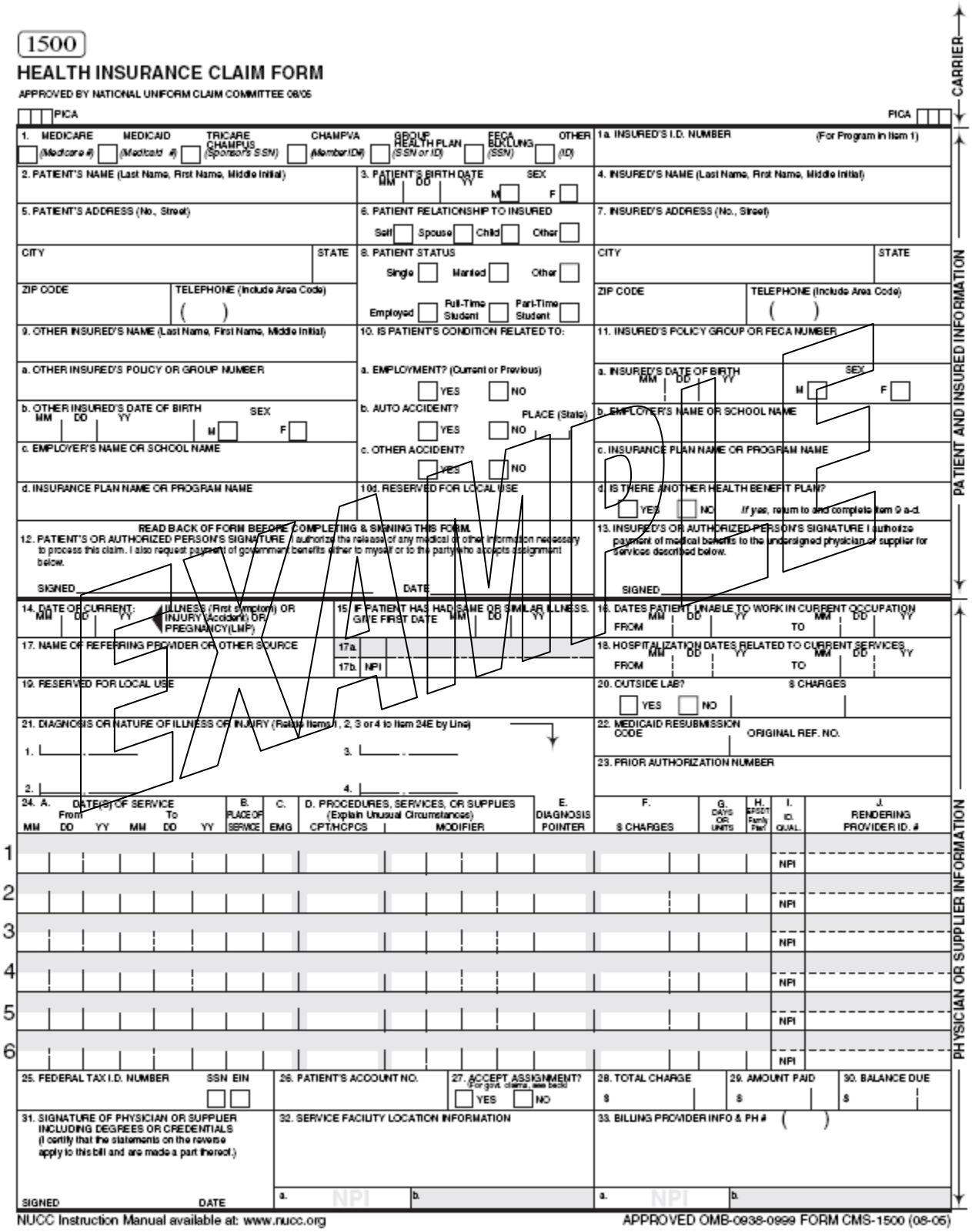
32. **OMIT**

33. **Provider's billing name, address, zip code, phone:** Enter provider name and address.

33a. Enter the NPI (either the agency/company NPI or if the provider is an individual provider, their individual NPI).

As a reminder: The Centers for Medicare & Medicaid Services (CMS) 1500 changed to accommodate the National Provider Identifier (NPI). If you are still using the old format of the CMS-1500, it will be rejected.

EXAMPLE OF CMS 1500 FORM



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

CHAPTER 4
REIMBURSEMENT PROCESS

Once the CMS-1500 is generated and checked for accuracy, it is sent or transmitted to the applicable insurance company claims office. Timely filing is mandatory, since third-party payers generally require filing within one year of the date of service; each insurance company has their own filing timelines - to be sure, check with them before filing your claim. Under ideal circumstances, the insurance company claims office will process the claim within three to six weeks. See page 56 for Arizona Revised Statute 20-3102—if a clean claim is submitted to an insurance company, by Arizona law, the insurance company has thirty days to process the claim. A clean claim is a claim that has correct information listed

With an assignment of benefits, obtained as part of the parent consent/participation, the provider should be paid the appropriate insurance proceeds. Most plans will enclose an explanation of benefits (EOB) to explain the calculations involved in the process. (See samples on pages 34-35).

Follow-up with the third-party payer is required when:

1. it is necessary to respond to requests for clarification or additional information,
2. an unusually long period of time has elapsed after the claim is filed without a response, or
3. the response is inadequate.

Inquiries from Third-Party Payors may include questions regarding an incomplete or inaccurate form, or requests for additional records to document or support the information submitted.

If using a billing service, it is only through trial and error that the provider's insurance representatives can become proficient in the effective follow-up process with third-party rules, which seem to change frequently. It is helpful if the provider's third-party specialist has knowledge of insurance terminology, claims processing methods across plans, and benefit structures of private and public plans.

Note: It is important to record claims activity - if it makes it easier for you, use the Billing Progress Notes (see example in this guide) to track your claims. If you need help from the Division, all the documentation is there!

If you haven't received an Explanation of Benefits from the insurance company in 45 - 60 days from date of submittal, and you have been in contact with the insurance company, trying to obtain either a payment or denial, notify the Benefits Coordinator and request help. We want to help you to succeed!

Insurance co-pays are built into your contracted rate from the Division. Therefore, co-pays are not allowed to be recouped from the consumer and/or family.

WAIVER PROCESS

If the insurance company **denies** the claim, the provider (or billing representative) will do the following:

1. Check the Explanation of Benefits (EOB) for accuracy (verify that the denial reason is correct) - see below for examples of acceptable denial reasons.
2. Complete a Waiver Request Form - see page 52 for an example of a completed Waiver Request Form (you can request the form be mailed or emailed to you by the Benefits Coordinator).
3. Submit the completed form *and* the EOB's by mail or fax to the Benefits Coordinator.
4. Providing the documentation received is correct and adequate, the Benefits Coordinator will write a waiver for the service, for the calendar year, *in most cases*. Most insurance plans benefits packages change with the calendar year, so if a therapy claim denies in February, chances are great that the claim would still deny in July or October. The waiver is written from the first date listed on the EOB through the end of the calendar year.
5. After receiving the completed waiver form, the provider can bill the Division as the primary until the end of the calendar year. If you're still seeing the same consumers in the new year that you had waivers on the previous year, you'll need to bill all insurances again. Plans change from year to year.

Acceptable Denial Explanations:

- **Not a covered benefit**
- **Benefits are exhausted.**
- **Not medically necessary**
- **Pre-existing condition**
- **Non-contracted provider**

The Division always pays the insurance plan's deductible, up to the provider's contracted rate.

Possible Explanation of Benefits (EOB) Explanations:

- Claim missing place of service code
- Diagnosis code does not correspond with CPT code
- Incorrect ICD-9-CM code with failure to use forth or fifth digits when required
- Duplicate claim
- Patient ineligible for dates of service
- Your claim was given individual consideration and reimbursed accordingly
- Provider number is not on file; contact Electronic Data Systems (EDS) enrollment for assistance
- Policy number missing/invalid/not on file
- Recipient name/number mismatch/missing/invalid
- Recipient ineligible for date of service billed/unknown
- Claim denied; provider name/number on claim doesn't match our files
- Other insurance indicated or missing/invalid
- Primary diagnosis missing/invalid
- Please resubmit on appropriate claim form
- Claim past timely filing limit
- Inappropriate procedure code

If you receive any of remarks listed above on the Explanation of Benefits you receive, call the insurance company for more clarification of the explanation, if needed.

What is a clean claim?

An electronic or paper claim that requires no further information, adjustment or alteration by the provider of services in order to be processed or paid by the health insurer.

What missing information triggers a claim return?

- Insured's ID number
- Date of birth
- Gender
- Insured's address
- Date of service
- Procedure code invalid
- Diagnosis code invalid

Explanation of Benefits (EOB)

Every health insurer, including Health Maintenance Organizations (HMOs), is required to provide the insured or subscriber with an EOB form in response to the filing of a claim.

The EOB must include at least the following:

1. Name of the provider of service.
2. Date of service.
3. Identification of the service.
4. Provider's charge.
5. The amount or percentage payable after deductibles, co-payment and any other reduction of the amount claimed.
6. An explanation of any denial, reduction, or any other reason for not providing full reimbursement for the amount claimed.
7. Telephone number or address where an insured may obtain clarification.
8. Information on how to file an appeal of a denial of benefits including the applicable timeframes to file.

ALWAYS call the insurance company for clarification of a denial that is un-clear!

PRETEND

Sample Explanation of Benefits

P.O. Box 663
Any town, AZ 85000

Date: 8/30/2008
Page: 1 of 1
Check# 00000001
Check Amt. $82.40

For questions regarding this statement or to file an appeal, please call (800) 555-5555.

Product	Member ID #	Patient Name	Pat Rel	Patient Account	Member Name	Control Number	Date Received	Provider of Svc.
HMO	W555-5-C000	Smith, Joe	Child	0000225	Smith, Joe Sr.	0012350576	07/16/08	Speech, Inc.

Patient	Dates of Svc	Proc. No.	Units of Svc	Billed Amt	Allowed Amt	Msg Code	Ded Amt	Co-pay Amt	Co-ins Amt	Amt paid
Smith, Joe	07/11/08	92506	1	200.00	103.00	A1	0.00	10.00	0.00	82.40

Message Code explanation:

A1 - The payment represents the insured's contractual agreement - claim paid at 80% of allowable.

Provider Name
Provider's address
Anytown, AZ 85000-0000

EXAMPLE OF AN EXPLANATION OF BENEFITS

WHERE THE SERVICE WAS DENIED

H.M.O. Health Group
1234 Easy Street
Any Town, AZ 85000
800-121-2121

Date:	09/23/08
TIN:	86-0000000
Enrollee:	Smith, Joe Sr.
Patient	Smith, Joe Jr.
Group #	123456
Group Name:	Atlas
Claim #	0123456789

PROVIDER EXPLANATION OF BENEFITS

Explanation of Benefits for Services provided by:
Speech, Inc.

This is NOT a bill

Date Of Svc	Svc Code	Total Charge	Not Covered	Reason Code	Disc. Amt.	Covered Amt.	Ded. Amt.	Co-pay Amt.	Balance	Paid At:	Payment Amt.
08/04/08	92507	120.00	120.00	KJ	0.00	0.00	0.00	0.00	0.00	0%	0.00
08/11/08	92507	120.00	120.00	KJ	0.00	0.00	0.00	0.00	0.00	0%	0.00
08/18/08	92507	120.00	120.00	KJ	0.00	0.00	0.00	0.00	0.00	0%	0.00
08/25/08	92507	120.00	120.00	KJ	0.00	0.00	0.00	0.00	0.0	0%	0.00

Payment: 0.00

Service Code

92507 INELIGIBLE

Reason code: KJ - Coverage excludes charges that are not the result of an injury or illness as described on page 26 & 27, definitions and page 12., C., of your plan coverage booklet.

You have the right to appeal to the Contract Administrator if you disagree with the decision made on your claim. An Appeal must be made in writing to the Contract Administrator no later than 45 days after you receive this notice of denial. An appeal must include the reasons for your appealing the denial and all pertinent information and documentation which will enable the Contract Administrator to review your claim. The appeal must be addressed to Claims/Appeals, H.M.O. Health Group, 1234 Easy St, Any Town, AZ 85000. Please call our customer service number for more information.

AND FINALLY —

Always use the most critical diagnosis first on your claim form.

Make sure the Explanation of Benefits (EOB) matches the date, type of service, and provider of service on the bill you are sending to the Division.

Anytime the insurance company reimbursement is not equal to or greater than what you would have received from the Division, you may still bill the Division to collect the remainder up to your contracted rate.

For families whose insurance company accesses a deductible, the Division always pays the deductible, up to the provider's contracted rate.

Don't be afraid to challenge the insurance company's decision, if you feel they are not giving the claim "every consideration". Explain why the services are medically necessary; send them treatment notes detailing the child's progress as a result of your services; ask the consumer's family to write or call, commenting on the child's progress, etc. If you get a denial, be proactive. Put your materials together to form an appeal and send the claim back to the insurance carrier's claims department, but be sure to mark it as a "claims appeal" so they don't think it's a new claim and start the process all over again. The time and effort you spend in appealing insurance claims can pay off, especially once you learn which ones will be worth the effort!

If you have billed the insurance company and have not received an EOB within 30 – 45 days, call the insurance company and check on the status of your claim. Sending in another claim only delays you – the insurance company more often than not denies the second submitted claim as a duplicate. The Division cannot accept an EOB with a reason code/explanation of "Duplicate claim".

If you're still unable to obtain a clean EOB, contact the Benefits Coordinator for help. Two suggestions:

1. See page 53 — fill out a Billing Progress Notes page is you're unable to get resolution from the insurance company and submit that page to the Benefits Coordinator for help.

2. Send the insurance company a letter requesting a claims determination (see example on page 37). If you copy the Arizona Department of Insurance on your letter, the Department will also track the progress of the determination. If patterns emerge, the Department of Insurance can go in and investigate an insurance company.

It may be easier to hire a billing agency to do your third party liability billing. Weigh the advantages and disadvantages of hiring someone. Ask for references and compare prices.

You can write a letter to the insurance company like the example below. Make sure you copy the Arizona Department of Insurance when submitting the letter. Or, you can go to the Department of Insurance website (www.id.state.az.us) and fill out their two-page Request for Assistance form and submit it along with all accompanying documentation to support your claim. See the next two pages for an example of the two page form.

Example letter to insurance company to request determination

Holly Johnson, Physical Therapist
4999 E. Fort Arizona Road
Any Town, AZ 85000

September 4, 2008

Reference: Member ID # 000054321-02
Ryan Selman

Pretend Healthcare
Attn: Claims/Appeals Dept.
PO Box 010101
Any Town , TX 78900-0101

Dear Claims/Appeals Department:

I am requesting a determination be made on the claim I submitted to Pretend Healthcare on July 1, 2008, for dates of service 6/04, 6/11, and 06/18/08 (see attached CMS 1500).

I called your provider line on July 31, 2008, and spoke with Charlene, who stated the claim wasn't in your system. I resubmitted the claim on August 4, 2008. Today I called again to check the status and was told the claim is pended for medical review.

Per Arizona Revised Statute §20-3102, health care insurers have thirty days to approve or deny claims.

Thank you for your assistance in expediting my claim as soon as possible.

Sincerely,

Holly Johnson

Holly Johnson

Attachment: (1)

cc: Arizona Department of Insurance
State of Arizona DES/DDD

ARIZONA DEPARTMENT OF INSURANCE ♦ 2910 N. 44th St., Ste. 210. ♦Phoenix, AZ 85018
Tel: 602-364-2499♦ Fax: 602-364-2505♦ Toll Free: 1-800-325-2548 ♦ Web Site: www.id.state.az.us

REQUEST FOR ASSISTANCE FORM

SECTION A: Information About You

Date:	Phone number:	Fax number:	
Your last name:	Your first name:	Your middle name/initial:	
Street address:	City:	State	Zip code:
May we contact you by e-mail: ☐ Yes ☐ No	E-mail Address:		

SECTION B: Information About the Insured (complete this section if the insured is someone other than yourself)

Name of the insured (if an individual, please provide last name, first name and middle name/initial):			
Insured's street address:	City:	State	Zip code:

SECTION C: Information About the Insurance Coverage

Name of the insurance company		Policy #:
Type of insurance (Life, health, auto, homeowners, fire, etc.)	Policy effective date:	State where purchased:

SECTION D: Type of Issue

For what type of issue are you requesting assistance?

☐ **Claim Denial**	☐ **Delays**	☐ **Policy Cancellation**
☐ **Premium Rates**	☐ **Refusal to Insure**	☐ **Agent Handling**
☐ **Other (please describe):**		

SECTION E: Statement of Facts

Please complete and attach the "Statement of Facts Form" or attach a brief statement that describes
- What the insurance company/agent has done or has failed to do; and
- What you would like the Department of Insurance to do to help you.

Please also provide copies of any pertinent documents related to your complaint.

By my signature, I attest that the information provided on and with this form is accurate to the best of my knowledge and ability, and that I understand that the facts relating to this complaint will become a matter of public record, pursuant to Arizona law.

Signature:_____

The Arizona Department of Insurance is an Equal Employment Opportunity agency that complies with the Americans with Disabilities Act (ADA) and the Arizonans with Disabilities Act. Persons with a disability may request materials in an alternative format by contacting our ADA Coordinator at (602) 364-3471 and should do so as early as possible to allow reasonable time to make necessary arrangements.

RFA (12/2007)

ARIZONA DEPARTMENT OF INSURANCE ♦ 2910 N. 44th St., 2nd Fl. ♦Phoenix, AZ 85018
Tel: 602-364-2499♦ Fax: 602-364-2505♦ Toll Free: 1-800-325-2548 ♦ Web Site: www.id.state.az.us

REQUEST FOR ASSISTANCE FORM

Statement of Facts

Date:	Your Name (Last, First, Middle):

Please describe what the insurance company/agent has done or has failed to do. Please also attach *copies* of any pertinent documents, such as: letters, forms, policies, notices, cancelled checks (front & back), emails, or other materials related to your complaint.

Please describe what you would like the Department of Insurance to do to help you.

GLOSSARY

Adjudicate - To determine whether a claim is to be paid or disallowed.

Adjuster - An individual, often referred to as a claims representative, who acts for an insurance company in the settlement of a medical claim.

Adjustments - Changes made to correct an error in billing, processing of a claim or as a result of retroactive rate change.

Allowed charges - The part of the reported charge that qualifies as a covered benefit, eligible for payment.

ALTCS - Arizona Long Term Care System

APIPA - Arizona Physician's Independent Practice Association

Assignment of benefits - An agreement between the insured and provider which authorizes the insurance carrier to pay benefits directly to the provider of services.

ASSISTS # - Stands for Arizona Social Service Information and Statistical Tracking System—The Division's former computer system name. Each consumer was assigned an ASSISTS number, which is still used by the new computer system, FOCUS.

AzEIP - Arizona Early Intervention Program

Beneficiary - A person eligible to receive benefits under a healthcare plan.

Benefit - An amount payable by an insurance plan for services covered by the plan.

Birthday rule - The rule associated with the process of coordination of benefits in which when both parents have healthcare coverage, the insurer of the parent whose birthday falls first in a calendar year becomes the primary carrier.

Capitation - A method of payment for healthcare services in which the provider is paid a fixed fee for each person enrolled in an insurance plan. The monetary allowance for each enrollee is usually based on average costs adjusted for age, sex, and so forth, not on the type or number of services rendered to individual patients.

Carrier - The insurance company, HMO or PPO that writes, underwrites, and/or administers the health insurance policy, HMO or PPO Plan, also referred to as the insurer.

Claim - The written or electronically submitted request for payment of benefits for therapy services; standardized claim form used is the Centers for Medicare & Medicaid Services (CMS) 1500.

Centers for Medicare and Medicaid Services (CMS) - Federal governmental agency responsible for the administration of the Medicare and Medicaid programs under the auspices of the Department of Health and Human Services.

COBRA - (Consolidated Omnibus Reconciliation Act of 1985) - Federal legislation which mandates to some persons who would otherwise lose group health insurance coverage the right to continue coverage under the group plan for a limited time period. Employees who terminate employment for any reason other than gross misconduct, those whose hours are reduced, and dependents of these employees may continue the group coverage for up to 18 months. Premium costs for COBRA coverage are paid entirely by the insured.

Coinsurance (Co-payment) - A provision of an insurance plan which stipulates the beneficiary's share of the cost of covered services, usually stated as a percentage of allowed charges.

Comprehensive medical insurance - A policy which provides both basic and major medical health insurance protection. Benefits are usually paid at a set percentage of all covered charges after satisfaction of a periodic deductible.

Consent - Voluntary agreement, based on an understanding of the nature of a particular action and the risks involved. The family normally signs their consent for the provider to bill their insurance company.

Coordination of benefits (COB) - When a patient is covered by more than one insurance, the plan provides for carriers to take into account benefits payable by another plan and determine primary and secondary responsibility.

Covered services - Those healthcare services provided to the patient which are stipulated by an insurance plan as eligible for benefit payments.

CRS - Children's Rehabilitation Services

Customary charge - A dollar amount representing the lowest charge to a consumer, including any discount, for a specific service during a specific period of time by an individual provider.

Current Procedural Terminology (CPT-4) - Listing of medical terms and identifying codes for reporting medical services and procedures, developed by the American Medical Association.

DDD - Division of Developmental Disabilities

Deductible - Specific dollars outlined in the insurance plan that must be paid before the benefits of the plan become payable.

Deductible Carryover - Allows for covered services incurred within the last three months of the year to be carried over and counted toward the next year's deductible.

Denial - A claim for which payment is disallowed.

Dependent - Those individuals, other than the insured, who are eligible for coverage under the plan; generally, the insured's spouse and children.

DES - Department of Economic Security

Direct service - Professional services provided in a face-to-face contact with the DDD consumer.

Disability income insurance - A type of health insurance that provides periodic payment, in replacement of income, when an insured is disabled due to illness, injury or disease.

DOS - Date Of Service

Duplicate claim - A claim that has been submitted or paid previously.

Durable medical equipment - Equipment which (1) can withstand repeated use and (2) is used to serve a medical purpose. Example: a wheelchair.

Effective Date - The date the insurance coverage begins.

Electronic claim - Processing and delivery of a claim from one computer to another through a form of magnetic tape or telecommunications.

Eligible - One who is qualified for benefits.

Eligibility file - A file containing individual records for all persons who are eligible for coverage by the plan.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment, a federally mandated program for eligible individuals under the age of 21.

ERISA - (Employee Retirement Income Security Act) - Congressionally enacted pension reform legislation of 1974 that includes stipulations which have evolved to provide insulation for self-funded plans, from individual state's insurance regulations.

Exclusions - Services, conditions, or products that are specifically listed in a policy as not covered.

Explanation of Benefits (EOB) - The insurance company's written explanation of a claim, showing what they paid or denied.

Fee for service - Payment by a third-party payer to providers of health services of specific amounts for service given.

Fiscal agent - An organization authorized to process claims.

FOCUS - The Division's computer system.

Gatekeeper - Refers to the physician(s) in prepaid healthcare plans who perform initial medical exams or screen prospective care prior to referral to other specialists or allied health professionals within or outside the plan.

Healthcare Financing Administration (HCFA) - Federal governmental agency responsible for the administration of the Medicare and Medicaid programs under the auspices of the Department of Health and Human Services. *NOTE: The name has been changed to Centers for Medicare and Medicaid Services (CMS).*

Healthcare Financing Administration Common Procedure Coding System (HCPCS) - Includes three levels of standardized procedure codes:

- Level I codes are CPT numeric procedure codes:
- Level 2 are national, HCFA, alpha-numeric (A through V) codes for procedures not included in CPT codes; and
- Level 3 are local (state) alpha-numeric codes (W through Z) for procedures to meet local coding needs.

Health Maintenance Organization (HMO) - An alternative delivery system in which enrollees pay a fixed payment for comprehensive healthcare services emphasizing preventative and primary care.

HIPAA - A Federal law passed in 1996 that allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care. Full name is "The Health Insurance Portability and Accountability Act of 1996."

Indemnity Health Plan - Indemnity health insurance plans are also called "fee-for-service." These are the types of plans that primarily existed before the rise of HMOs, EPOs, and PPOs. With indemnity plans, the individual pays a pre-determined percentage of the cost of health care services, and the insurance company (or self-insured employer) pays the other percentage. For example, an individual might pay 20 percent for services and the insurance company pays 80 percent. The fees for services are defined by the providers and vary from physician to physician. Indemnity health plans offer individuals the freedom to choose their health care professionals.

Indirect service - Directing the teachers/aides in providing related services in the classroom as non-direct intervention with the child.

In-network - Providers or health care facilities which are part of a health plan's network of providers with which it has negotiated a discount. Insured individuals usually pay less when using an in-network provider, because those networks provide services at lower cost to the insurance companies with which they have contracts.

Insured - the person who is the primary policyholder in relation to the insurance plan.

Intermediary - Insurance carrier or data processing company which processes Medicare or Medicaid claims on behalf of the government.

International Classification of Diseases, 911 Revision, Clinical Modifications (ICD-9-CM) - Coding manual developed by the National Center for Health Statistics and others to standardize disease and procedures classification, A listing used by providers in coding diagnosis on claims.

Major medical insurance - Health insurance policy that provides for reimbursement of major illness and injury to insured, usually includes a deductible then provides for expansive benefits.

Maximums - Upper dollar limit a carrier will reimburse for a specific benefit or policy.

MCP - Mercy Care Plan

Medicaid - A government-sponsored medical assistance program that enables eligible recipients to obtain medical benefits outlined within the state Medicaid guidelines.

Medically needy - Individuals whose income and resources equal or exceed those levels for assistance established under a State or Federal plan, but are insufficient to meet their costs of health and medical services.

Medical necessity - A service reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a disability or cause physical deformity or malfunction, and if there is no other equally effective course of treatment available or suitable for the recipient requesting the service.

Medical record - Data or information retained in some media form and related to the health status of and treatment rendered to a patient.

Medigap Insurance Policies - Medigap insurance is offered by private insurance companies, not the government. It is not the same as Medicare or Medicaid. These policies are designed to pay for some of the costs that Medicare does not cover.

Non-covered services - (1) Services not medically necessary; (2) Services provided for the personal convenience of the patient; or (3) Services not covered under the healthcare plan.

Non-participating Provider (Non-Par) - A provider who has **not** both signed a contract with a carrier (HMO or PPO) nor agreed to provide services under the terms of the carrier and/or specific plan.

NPI - National Provider Identifier.

Out-of-Plan (Out-of-Network) - This phrase usually refers to physicians, hospitals or other health care providers who are considered non-participants in an insurance plan (usually an HMO or PPO). Depending on an individual's health insurance plan, expenses incurred by services provided by out-of-plan health professionals may not be covered, or covered only in part by an individual's insurance company.

Over-utilization - Any usage of healthcare programs by providers and/or recipients not in conformance with both State and Federal regulations and laws (include fraud, abuse and defects in level and quality of care).

Participating provider - A medical care provider who has established a contractual relationship with a third-party payer to provide certain services to members of a plan.

Payment - Reimbursement to the provider of services for a claim incurred that is a covered benefit.

PCP - Primary Care Provider

Peer Review Organization - The utilization and quality control review unit that reviews the validity of diagnostic information: the completeness, adequacy and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of services provided. Many professional associations have established quality of care and peer review organizations, standards and committees who complete the review process.

Plan of Care - Written statement that details the patient's condition, functional level, treatment goals and objectives, the physician's modifications to the plan, and plans for ongoing care, and potential for discharge from treatment.

POS - Place Of Service

Pre-certification - The process of providing required notice of proposed treatment to the patient's third-party payer.

Pre-existing Condition - An injury, disease, or disability that afflicted the insured prior to issuance of the insurance policy, and which frequently excludes the insured from coverage totally or for a specific period of time.

Preferred Provider Organization (PPO) - A PPO is similar to an HMO that uses the open panel plan of preferred providers. Individual healthcare practitioners become preferred providers and are paid on a negotiated fee-for-service basis by a purchaser group. The patient routinely participates in the healthcare plan of a commercial carrier, which monitors utilization of service.

Primary Care Provider (PCP) - A health care professional (usually a physician) who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a "quarterback" for an individual's medical care, referring the individual to more specialized physicians for specialist care.

Primary carrier - Insurance carrier or HMO/PPO which has first responsibility for payment under coordination of benefits.

Primary diagnosis - The condition considered to be the patient's major health problem for which treatment is rendered and on which the physician's claim is based.

Prior authorization - Process of obtaining permission, to provide services, from the carrier who will reimburse the service.

Procedure code - A statistically based code number used to identify medical procedures performed by a provider.

Progress note - A dated, written notation in the child's record detailing an encounter with the child and the child's' response to the encounter.

Provider - Provider is a term used for health professionals who provide health care services. The term refers to other health care professionals such as Occupational, Physical therapists, and Speech Language Pathologists.

Provider agreement - A contract between the provider and carrier that states the conditions of participation and reimbursement.

Provider number - A nine-character code assigned to each provider of AHCCCS services in Arizona for identification purposes.

Quality assurance program - Activities that measure the kind and degree of excellence of healthcare delivered. Quality of care is measured against pre-established standards. There are federal and state guidelines that relate to quality assurance programs within HMOs.

Reasonable and Customary Fees - The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the amount of money they will approve for a specific test or procedure. If the fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the provider will reduce the charge to the amount that the insurance company has defined as reasonable and customary.

Reimbursement - The amount of money remitted to a provider.

Release of Information - The patient's (or parent or guardian's) signature on a consent form that allows the release of information necessary to the settlement of the claim.

Secondary carrier - The insurance carrier that is second in responsibility within the coordination of benefits.

Short-Term Medical - Temporary coverage for an individual for a short period of time, usually from 30 days to six months.

Stop-loss - The dollar amount of claims filed for eligible expenses at which point you've paid 100 percent of your out-of-pocket and the insurance begins to pay at 100%. Stop-loss is reached when an insured individual has paid the deductible and reached the out-of-pocket maximum amount of co-insurance.

Suspended claim - "In process claim" which must be reviewed and resolved.

Third-party payer - A public or private entity that insures against risk of loss or reimburses for expenses incurred in relation to the receipt of medical care services.

UCR - (usual customary reasonable) - A third-party's method of benefit calculation which takes into account charges billed by all providers within a particular discipline and geographic region.

Unit - A session of therapeutic treatment or diagnostic assessment.

Waiting Period - A period of time when you are not covered by insurance for a particular problem.

Q & A

Q. What if the consumer has AHCCCS only?

A. Bill the Division only.

Q. What if the consumer has KidsCare only?

A. Bill the Division only.

Q. What if the consumer has private insurance and AHCCCS? Do I have to bill both?

A. Bill the private insurance first, the Division second. You do not have to bill the AHCCCS plan.

Q. What if the consumer has none of the above?

A. Bill the Division only.

Q. What if the family doesn't know if the services we provide are covered by their private insurance?

A. Call the insurance company for benefits verification.

Q. What if we find out by calling the insurance company that the services aren't covered?

A. Get a written statement from the insurance company, bill the Division only, and send the denial to the Benefits Coordinator for a waiver.

Q. What if we bill the insurance company but they don't pay the claim?

A. Send or fax the Explanation of Benefits to the Benefits Coordinator for a waiver.

Q. Should we bill them the next time?

A. That depends on the reason they didn't pay it. If the services just aren't covered, don't bill them any more - only bill the Division.

Q. What if we bill the insurance company and they tell us the claim is allowable, but they don't send us any money because the deductible isn't met?

A. Bill the Division, listing the amount the insurance company paid to the deductible. The Division pays for deductibles, up to your contracted rate.

Q. Should we bill them the next time?

A. Yes! Each time you bill them, they will subtract the amount left of the deductible from what they would have paid you. As soon as the deductible equals what you've billed them, the deductible will be "satisfied", and you will receive payments from that point on.

Q. What if we bill insurance and they ask for copies of daily notes, goals, treatment plans, scripts, etc.? Can we send those things to them?

A. Definitely! Send them what they need to pay you! Be sure everything you send them is legible and professional. It is your responsibility to convince the insurance company that you are providing a necessary and valuable service to the child. Ask if you are able to fax them what is needed. Saves you time.

Q. What if the family has two insurance carriers?

A. Bill the primary carrier first. When you receive their payment and EOB, bill the secondary carrier if you have not been paid in full up to your contracted rate amount. Be sure to attach a copy of the primary carrier's EOB to the bill for the secondary carrier. If, after billing both carriers, you still have not received payment equal to or greater than the Division rate, bill the Division for the remainder up to your contracted rate.

Q. What do I do with the claims that are paid smoothly, and I receive more than the Division rate every time? Do I have to let the Division know that?

A. Yes. You will need to bill the Division for the claims you are paid on by an insurance company so that the Division knows that you provided the service, what you were paid for it, and how much money the program saved by not having to pay you because the insurance company did. This is very important information, and everyone must cooperate in providing it to the Division - it is also in keeping with your contract with the Division.

Q. What if we are not a preferred provider and there is no reimbursement available to non-preferred providers?

A. You can ask how you can become a preferred provider. Generally, however, there is a lengthy process to be accepted as a preferred provider, but you may want to pursue it, especially if there are a large number of families in your area who have the same insurance carrier. Plus, you'll most likely make more than you would by billing just the Division, and pick up more private consumers as well.

Q. What if they review everything and decide not to pay us?

A. You have to decide how hard and how long you want to appeal their decision. If you feel you have made your best case for payment, and can't do anymore, bill the Division and attach the Explanation of Benefits from the insurance company with the final ruling. If you feel the insurance denial is unjust, or that they have overlooked something, appeal their decision.

Q. Whose responsibility is it to notify the provider of changes to a family's insurance policy?

A. It's the provider's responsibility to notify the Division of a new policy or policy termination. Verify current coverage with the family at least quarterly.

Q. What if a provider can't get a response from an insurance company regarding their claims submission?

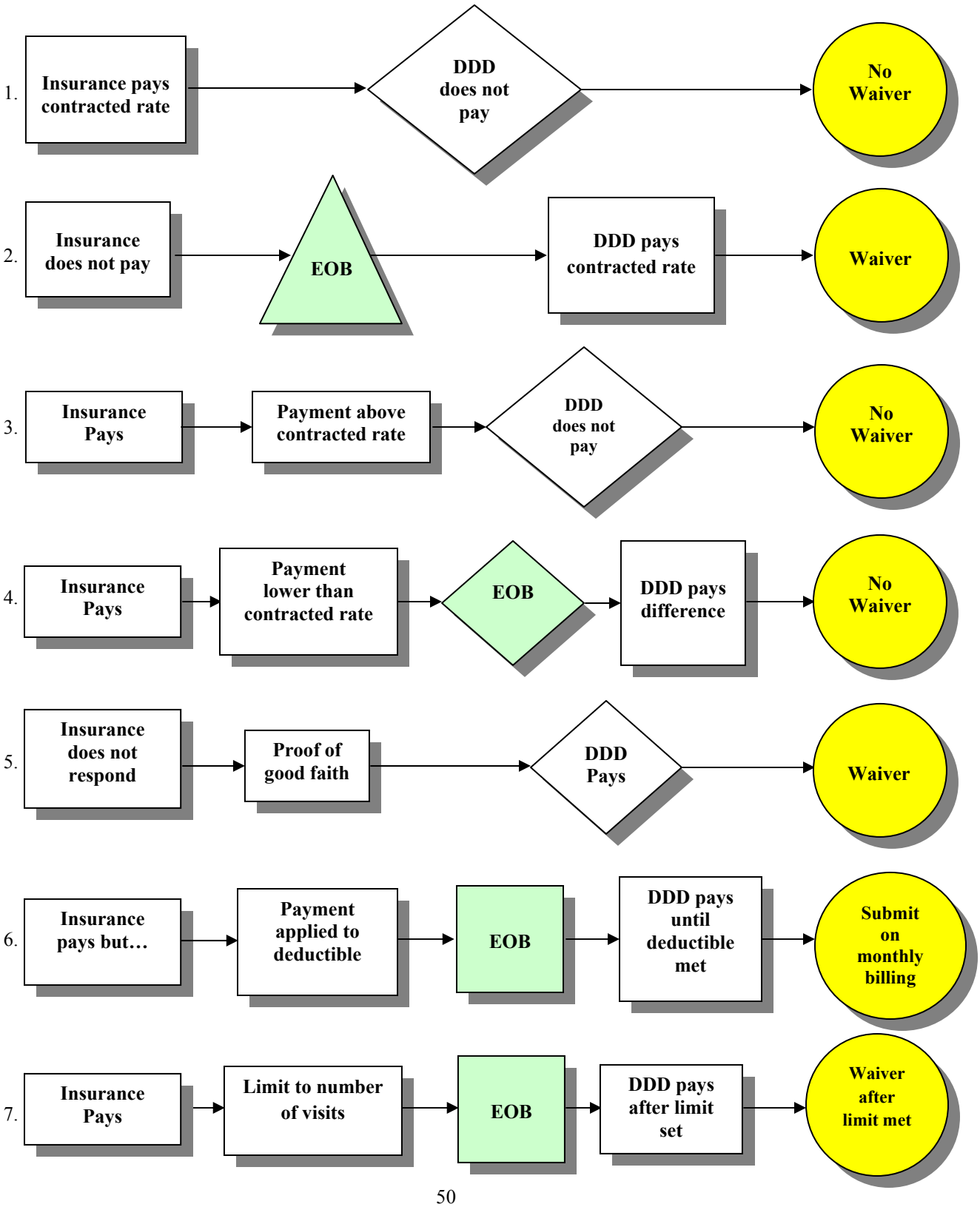
A. Per Arizona Revised Statutes, insurance companies have thirty (30) days to pay or deny a claim (see statutes at the end of this guide). If, after having exhausted all attempts at obtaining a payment or denial from the insurance company within the first 60 days after claims submittal, notify the Benefits Coordinator for help.

Q. What if I don't want to do the insurance billing myself?

A. You can always pay a billing service to bill insurance claims for you, for a fee you and the billing service agree upon.

Third Party Billing Scenarios – The Seven Steps to Third Party Billing

In all cases the Therapist must bill the insurance carrier (Third Party) before billing DDD



INSURANCE TELEPHONE LISTING

Aetna - HMO Policies	**800-624-0756**
Aetna - PPO Policies	**888-632-3862**
American Benefits	**602-264-1804**
AZ Benefits Options - Harrington	**888-999-1459**
Blue Cross Blue Shield	**800-232-2345**
BC/BS - Out of state verification	**800-676-2583**
Cigna	**800-244-6224**
Fortis (Assurance)	**800-325-8385**
HealthNet	**800-289-2818**
Humana	**800-367-7587**
PacifiCare	**800-283-7525**
PacifiCare (PPO Policies)	**866-316-9776**
Schaller-Anderson Healthcare, LLC	**866-289-6195**
Southwest Service Administration	**800-474-3485**
TriCare	**888-874-9378**
United Healthcare	**800-842-3210**

The numbers listed above are subject to change—always refer to your consumer's insurance card for the most current phone number.

Waiver Request Form example

Listed below is an example of how to fill out a Waiver Request Form. You can request a full-size form be emailed or sent to you by the Benefits Coordinator.

WAIVER REQUEST FORM

PROVIDER: Your name PROVIDER ID # Your provider # with the Division

ADDRESS: Your address CITY/STATE/ZIP: City, State and Zip

CONTACT PERSON: Your name or billing person PHONE # Your phone number FAX # Your fax number, if applicable

CONSUMER NAME	ASSISTS ID	SERVICE	INSURANCE COMPANY	INS CODE	WAIVER GRANTED YES	NO	START DATE	END DATE	DENIAL CODE
1 List consumer's name	ASSIST's ID #	Type	Name of Ins.Co.	These areas are filled out by the					
2				Benefits Coordinator					
3									
4 You can list up to 15									
5 consumers per Waiver									
6 Request form.									
7									
8									
9									
10									
11									
12									
13									
14									
15									

REQUESTED BY: Your signature AUTHORIZED BY: Benefits Coordinator's signature

DATE: the date you sign DATE: the date Benefits Coordinator signs

DENIAL CODES:
(1) Applies to Deductible (2) Insurance change (3) No TPL (4) Other

Billing Progress Notes

Date: _____

Provider's Name: _____

Consumer's Name: _____

ASSISTS#: _____

Date billed to insurance:	Date of service:	Amount billed:

Inquiry information by phone or fax to insurance company:

Map of Arizona by District

Administration

District I office - Phoenix

District II office - Tucson

District III office - Flagstaff

District IV office - Yuma

District V office - Apache Junction

District VI office - Bisbee

District Offices / phone numbers

Administration	1789 W. Jefferson P.O. Box 6123 Phoenix, AZ 85005	602-542-0419
District I	1990 W. Camelback Road Phoenix, AZ 85015	602-246-0546
District II	400 W. Congress, Ste 500 Tucson, AZ 85701	520-628-6800
District III	2705 N. 4th St, Ste A Flagstaff, AZ 86004	928-773-4957
District IV	350 W. 16th St, Ste 232 Yuma, AZ 85364	928-782-4343
District V	110 S. Idaho Road, Ste 240 Apache Junction, AZ 85219	480-982-0018
District VI	209 Bisbee Road Bisbee, AZ 85603	520-432-5620
Arizona Training Program at Coolidge (ATPC)	2800 N. Highway 87 P.O. Box 1467 Coolidge, AZ 85228	520-723-4151

Arizona Revised Statutes that apply to billing insurance

20-3102. Timely payment of health care providers' claims; grievances

A. A health care insurer shall adjudicate any clean claim from a contracted or noncontracted health care provider relating to health care insurance coverage within thirty days after the health care insurer receives the clean claim or within the time period specified by contract. Unless there is an express written contract between the health care insurer and the health care provider that specifies the period in which approved claims shall be paid, the health care insurer shall pay the approved portion of any clean claim within thirty days after the claim is adjudicated. If the claim is not paid within the thirty-day period or within the time period specified in the contract, the health care insurer shall pay interest on the claim at a rate that is equal to the legal rate. Interest shall be calculated beginning on the date that the payment to the health care provider is due.

B. If the claim is not a clean claim and the health care insurer requires additional information to adjudicate the claim, the health care insurer shall send a written request for additional information to the contracted or noncontracted health care provider, enrollee or third party within thirty days after the health care insurer receives the claim. The health care insurer shall notify the contracted or noncontracted health care provider of all of the specific reasons for the delay in adjudicating the claim. The health care insurer shall record the date it receives the additional information and shall adjudicate the claim within thirty days after receiving all the additional information. The health care insurer shall also pay the approved portion of the adjudicated claim within the same thirty day period allowed for adjudication or within the time period specified in the provider's contract. If the health care insurer fails to pay the claim as prescribed in this subsection, the health care insurer shall pay interest on the claim in the manner prescribed in subsection A.

C. A health care insurer shall not delay the payment of clean claims to a contracted or noncontracted provider or pay less than the amount agreed to by contract to a contracted health care provider without reasonable justification.

D. A health care insurer shall not request information from a contracted or noncontracted health care provider that does not apply to the medical condition at issue for the purposes of adjudicating a clean claim.

E. A health care insurer shall not request a contracted or noncontracted health care provider to resubmit claim information that the contracted or noncontracted health care provider can document it has already provided to the health care insurer unless the health care insurer provides a reasonable justification for the request and the purpose of the request is not to delay the payment of the claim.

20-3102. Timely payment of health care providers' claims; grievances, con't

F. A health care insurer shall establish an internal system for resolving payment disputes and other contractual grievances with health care providers. The director may review the health care insurer's internal system for resolving payment disputes and other contractual grievances with health care providers. Each health care insurer shall maintain records of health care provider grievances. Semiannually each health care insurer shall provide the director with a summary of all records of health care provider grievances received during the prior six months. The records shall include at least the following information:

1. The name and any identification number of the health care provider who filed a grievance.
2. The type of grievance.
3. The date the insurer received the grievance.
4. The date the grievance was resolved.

G. On review of the records, if the director finds a significant number of grievances that have not been resolved, the director may examine the health care insurer.

H. This section does not require or authorize the director to adjudicate the individual contracts or claims between health care insurers and health care providers.

I. Except in cases of fraud, a health care insurer or contracted or noncontracted health care provider shall not adjust or request adjustment of the payment or denial of a claim more than one year after the health care insurer has paid or denied that claim. If the health care insurer and health care provider agree through contract on a length of time to adjust or request adjustment of the payment of a claim, the health care insurer and health care provider must have the same length of time to adjust or request adjustment of the payment of the claim. If a claim is adjusted, neither the health care insurer nor the health care provider shall owe interest on the overpayment or underpayment resulting from the adjustment, as long as the adjusted payment is made or recoupment taken within thirty days of the date of the claim adjustment.

J. This chapter does not apply to licensed health care providers who are salaried employees of a health care insurer.

K. If a contracted or noncontracted health care provider files a claim or grievance with a health care insurer that has changed the location where providers were instructed to file claims or grievances, the health care insurer shall, for ninety days following the change:

1. Consider a claim or grievance delivered to the original location properly received.
2. Following receipt of a claim or grievance at the original location, promptly notify the health care provider of the change of address through mailed written notice or some other written communication.

20-462. Timely payment of claims

A. From and after July 15, 1986 any first party claim not paid within thirty days after the receipt of an acceptable proof of loss by the insurer which contains all information necessary for claim adjudication shall be required to pay interest at the legal rate from the date the claim is received by the insurer. The interest shall be calculated on the amount the insurer is legally obligated to pay according to the terms of the insurance contract under which the claim is being submitted.

B. For purposes of determining whether the claim has been paid within thirty days, the date of payment shall be deemed to have been received by the addressee on the date shown by the postmark or other official mark of the United States mail stamped on the payment envelope. If the receipt disputes the date where there is no mark or the mark is not legible, the sender may establish the mailing or transfer date by competent evidence.

C. This section shall not apply to:

1) Claims submitted for payment under Medicare, title XVIII of the social security act (42 United States Code section 1301).

2) Claims submitted under a Medicare supplement contract where, according to the terms of the supplement contract, claims will be based upon the amount paid by Medicare.

3) The payment of a claim shall not be overdue during any period in which the insurer is unable to pay such claim because there is no recipient who is legally able to give a valid release for such payment, or in which the insurer is unable to determine who is entitled to receive such payment, if the insurer has promptly notified the claimant of such inability and has offered in good faith to promptly pay said claim upon determination of who is entitled to receive such payment.

4) Claims submitted to a person who is the processing agent for a foreign insurer or other person providing an insurance program for retirees residing in Arizona.

5) Claims denied in good faith within thirty days after receipt of acceptable proofs of loss.

D. This section shall apply only to claims that are to be paid by the insurer directly to the insured, to a beneficiary named in the contract, or to a provider who has been assigned the right to receive benefits under the contract by the insured.

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NOTES